Government of **Western Australia**
Department of **Health**

Principles and Best Practice for the Care of People Who May Be at Risk of Exhibiting Violent or Aggressive Behaviour

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Contents

1. Introduction

Violent and aggressive incidents are not unusual in mental health care settings. Dealing with these incidents is a significant challenge for clinicians, managers, admission/administration staff, consumers, carers/family, the personal support person, and visitors.

Fuller (2015) describes how individuals organise their daily life around their perceptions of how safe the world is, their vulnerability and their self-worth.[1] Physical assault violates these assumptions, resulting in fundamental changes in the way they perceive and interpret the world around them.

Lanctôt and Guay (2014) reviewed the literature regarding exposure to workplace violence, including 68 studies, and concluded that their review:

> '… demonstrates that there is a growing body of evidence suggesting that the outcomes of workplace violence are not only profound but multiple.'[2]

Violence has a significant impact on the victim, often with long lasting or permanent effects. Consequently, organisations carry liability and struggle to balance obligations to provide a safe environment for consumers and staff while delivering effective care.[3] If protocols and procedures are not in place to proactively guide care before, during and after violent and aggressive incidents occur, staff will inevitably feel isolated, unsupported and perhaps even fearful about going to work. This results in less than optimum care for people who may exhibit violent or aggressive behaviour, possibly discouraging them from engaging in future treatment, poor experiences for other consumers, and a demoralised workforce.

Mental health services must also consider how violent or aggressive incidents impact visitors, carers/family members and/or the personal support person, who may be victims of the consumer's aggression or violence, may have to deal with the aftermath or consequences and may have feelings of responsibility. In a similar way, in care settings, other consumers may be unable to escape and therefore feel vulnerable to violent or aggressive incidents and their consequences.

There is no adequate model to explain the emergence or escalation of violence or aggression in the mental health care setting. In addition to the consumer, features of the environment or system[4] or staff may have an impact.[5] While the focus is normally on the consumer and to a lesser extent the environment, the effects of emotional reactions by staff on the escalation of aggression is well documented but often not readily acknowledged.[6] Sometimes, staff may regard the consumer as being difficult or disruptive if they perceive them as reluctant to accept recommended treatment or if they are displaying aggression that staff believe is not a result of mental illness and can be controlled. Staff perception of the aggressive incident can affect their resulting emotions.[7] This can have a negative impact on the interaction with the consumer and may, in itself, be a contributing factor towards the aggression.

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[1] Fuller G (2015). The serious impact and consequences of physical assault. *Australian institute of Criminology, Trends & Issues in Crime & Criminal Justice,* 496.
[2] Lanctôt N and Guay S (2014). The aftermath of workplace violence among healthcare workers: A systematic literature review of the consequences. *Aggression & Violent Behaviour*, 19: 492-501.
[3] Ibid
[4] Cooke D and Wozniak E (2010). PRISM applied to a critical incident review: A case study of the Glendairy prison riot and its aftermath in Barbados. *International Journal of Forensic Mental Health*. 9(3): 159-172
[5] Ibid
[6] Haugvaldstad M and Husum T (2016). Influence of staff's emotional reactions on the escalation of patient aggression in mental health care. *International Journal of Law & Psychiatry*, 49: 130-137.
[7] Drach-Zahavy A, Gldblatt H, Granot M, Hirshmann S and Kostinski H (2011). Patients' aggression in psychiatric settings. *Qualitative Health Research*. 22(1): 45-53.

2. Scope

This document provides best practice principles and evidence in relation to the clinical care of people with mental health issues who may be at risk of exhibiting violent or aggressive behaviour while receiving mental healthcare. It has been developed to provide guidance to services in developing local policies. It is applicable across all age groups and all service settings.

While this document is concerned with eliminating or reducing violent or aggressive incidents through using best practice and the most appropriate care, it does not address how violent or aggressive incidents should be managed physically. Other guidelines and protocols will be in place covering this topic. This document also does not discuss suitable medication or details of its application in the clinical care of people who exhibit violence or aggression.

It is important to acknowledge the well-established link between suicidality and violence and the significance of assessing suicide risk in any consumer making homicidal threats.[8] Therefore, this document should be read in conjunction with the supporting document Principles and Best Practice for the Care of People Who May Be Suicidal.

Where the sharing of information with 'family, carers or personal support person' is referenced within this document, the treating clinician should be cognisant of the wishes of the consumer, and where the treating clinician considers it is safe to do so, to abide with an explicit request from adult consumers that information is not shared with others (which must be documented in the clinical file).

3. Values

The values underpinning this document promote care that is:

- recovery-oriented
- person-centred
- trauma-informed
- culturally competent
- developmentally appropriate.

3.1 Recovery-oriented care

Recovery-oriented practice supports people in taking responsibility for their own recovery and well-being and pursuing their life goals. In any setting, when clinicians are recognising and responding to a person who may become violent or aggressive, recovery-oriented care involves sharing responsibility for safety with consumers to the greatest extent possible, creating opportunities for the person to regain their self-control and supporting their autonomy to pursue their life goals.

[8] Moberg T, Stenbacka M, Jonson E, Nordstrom P, Asberg M and Jokinen J (2014). Risk Factors for Adult Interpersonal Violence in Suicide Attempters. *BioMed Central Psychiatry*, 14: 195.

3.2 Person-centred care

Person-centred care is based on the principles of personhood, individualised care and empowerment. In providing clinical care to people who may become violent or aggressive, it is necessary to consider the whole person within their social context, recognising their unique needs, experiences, values and preferences and supporting self-determination in decision making.

3.3 Trauma-informed care

Many people who access mental health services have experienced trauma in their lives. Trauma-informed approaches to care assist in creating physical, psychological and emotional safety for individuals who may become violent or aggressive and should also include awareness of the emotional and physical safety of carers/family, staff and other consumers around the person. Using least restrictive practice is one way by which treatment can be delivered in keeping with this care approach.

3.4 Culturally competent care

Cultural competence enables clinicians to provide care in cross-cultural situations including with Aboriginal people, those from ethnoculturally and linguistically diverse backgrounds and people from the LGBTQIA+ communities. An awareness of the cultural values and beliefs about health and illness that are held by an individual and their family is an important consideration in the way that care is provided.

3.5 Developmentally appropriate

Planning services and approaches should respond to the needs of younger people. Developmentally appropriate care considers the level of physical, social, emotional and intellectual development of a child. This applies in particular to those circumstances where children under the age of 18 are cared for in adult environments, such as emergency departments (EDs) and adult wards.

4. Assessment and risk

4.1 Assessment

The most effective strategies to prevent or reduce violence or aggression are founded on a comprehensive evaluation of the person, which can only be achieved by a full psycho-social assessment encompassing historic, cultural and current social and psychiatric factors. The person's current mental state and mental health symptoms, history of aggression or violence, history of abuse and self-harm, developmental history, triggers, and previous response to treatment are all necessary components contributing to a psychiatric diagnosis and formulation. Any history concerning relevant medical or organic issues (for example trauma, drug interaction, sepsis, or stroke in the elderly) should be investigated, especially if the person's behaviour has been out of character. A physical and/or neurological examination should be conducted where relevant and an appropriate specialist should be consulted.

The clinician should demonstrate genuine empathy and try to understand as much as possible about the individual as a person, not just as a consumer, and consider how they (the clinician)

would feel or react if they were in the consumer's place. This should be a dynamic process of collaboration with the consumer and carer or personal support person which acknowledges past experience, taking any advance directives into account where they exist (noting that very few consumers have an advance directive). The clinician should gain an understanding of the usual context of violence or aggression for the individual, which includes their input about their feelings and behaviours when acting aggressively or violently. It is important to try to ascertain early in the process what the consumer actually wants and expects and to also be aware of any social, family or legal difficulties. Medical issues, especially pain and discomfort, should be addressed promptly.

Seeking the consumer's opinion about what risk exists and what may reduce it can be valuable as a way to involve them in their own care, as a means to discover their understanding of the situation and also to encourage them to consider precursors and the outcomes of aggression or violence.

> 'Encouraging clients to assess their own risk and protective factors, for example by means of semi-structured interview, gives them the opportunity to share their own perspective on the presence of each domain. This enhances client insight into the importance of specific factors, but often also brings forth previously undiscussed issues and opportunities.'[9]

4.2 Risk

In providing care where there is a risk of violence or aggression there should be a balance between the safety of the carers/family, personal support person, mental health staff and other consumers, and the treatment and freedom of the individual receiving care. While safety is the primary consideration, it is important that care is provided using least restrictive practice. An overestimation of risk may result in unnecessary constraints on the consumer and costly interventions.[10]

The public and policymakers have an expectation that accurate assessment of the risk of mental health consumers exhibiting violent or aggressive behaviour should be a core skill for mental health professionals. Staff should be provided with the ongoing training and professional development required for risk assessment, mitigation and management, including opportunities for reflective practice, consultation with others and individual supervision.

Some factors affecting risk will be long term and unlikely to change whereas others will be more fluid and variable. There should be clear differentiation between static, immutable factors (e.g. gender, history of violence) and dynamic factors (e.g. treatment compliance, psychosocial stress), which may be modifiable. As some aspect of the risk will normally be variable to a greater or lesser degree, risk assessment should be a routine, ongoing process. Risk assessment is an evaluation of danger or threat in the present situation and not a predictor of future events. Assessment should be sensitive to the individual and should not result in

[9] de Vries Robbé M and Willis G (2017). Assessment of protective factors in clinical practice. *Aggression and Violent Behavior*. 32: 55-63.

[10] Miller H A (2006). A dynamic assessment of offender risk, needs, and strengths in a sample of general offenders. *Behavioral Sciences & the Law*, 24: 767–782.
cited in: de Vries Robbé M and Willis G (2017). Assessment of protective factors in clinical practice. *Aggression and Violent Behavior*, 32: 55-63.

unnecessary restrictions where no risk exists and should be performed in accordance with the Chief Psychiatrist's Standards for Risk Assessment and Management.[11]

The ED is a setting where staff frequently witness violent and aggressive incidents and are regularly required to assess risk. While this can be difficult in a busy environment, it is essential that an objective view is maintained so that the assessment is as accurate and meaningful as possible. A review of restrictive practices conducted by New South Wales Health (2017) found that the culture in some EDs was 'overtly stigmatising and discriminatory towards mental health consumers' and that 'frequently repeated assertions that mental health consumers are dangerous until proven otherwise result in a lowering of the threshold for the use of most-restrictive rather than least-restrictive options'.[12]

Risk assessment tools, including the mandated Risk Assessment and Management Plan (RAMP), should only be elements of a full assessment, particularly those tools that require the grading of risk at one of a number of 'risk levels', which can often be meaningless when taken to be a predictor of future behaviour.[13] All risk tools currently available have their shortcomings and the clinician should be wary of those that are simply a list of tick-boxes. Many tools may best serve as an 'aide memoire' for issues that should be considered as part of structured clinical judgement, but they should never be used in isolation to arrive at a simple 'risk rating' that determines the course of action. However, these tools can be of use in determining that some level of risk exists and have value as part of a thorough clinical assessment. Once risk has been recognised, the emphasis should not be on the attempted prediction of how and when violence or aggression will occur, but rather what can be done to reduce or prevent it.

4.3 Recognising potential factors for violence and aggression

Very few mental health consumers exhibit violence or aggression and there is no single clinical picture associated with their occurrence. Symptoms of mental illness are dynamic in nature and fluctuate. Therefore, when investigating the association between mental illness and any violent behaviour, it is important to establish whether a person was symptomatic when the violent incident occurred and the type, nature and influence of the symptoms. Cognitive issues like impaired judgement or reasoning ability, lack of insight, a reduced threshold for aggression, impulsivity or unusual affective responses may exist as stable factors that may occur independent of symptomatic changes. There can sometimes be an unquestioning assumption about a link between mental illness and violence.[14]

From a statistical perspective, the best predictor of violence or aggression is a history of the same; however, certain social or environmental factors may have a significant influence. It should be stressed that the importance of those factors is based on statistical probability and, therefore, by definition, will not apply in all cases. It is essential to consider any potential factors with regard to the person's physical and social context, as these may be modifiable, which consequently may affect the impact a particular factor may have.

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[11] Chief Psychiatrist of Western Australia (2015). *Chief Psychiatrist's Standards for Clinical Care*. Western Australia.

[12] New South Wales Health (2017). *The review of seclusion and restraint observation of consumers with a mental illness in NSW health facilities*. http://www.health.nsw.gov.au/patients/mentalhealth/Documents/report-seclusion-restraint-observation.pdf

[13] Sigh J P, Fazel S, Gueorguieva R and Buchanan A.
Rates of violence in patients classified as high risk by structured risk assessment instruments. *British Journal of Psychiatry*, 204(3): 180-187.

[14] Langan J (2010). Challenging assumptions about risk factors and the role of screening for violence risk in the field of mental health. *Health, Risk & Safety*, 12 (2): 85-100.

4.3.1 Serious mental illness

Resnik (2012) suggested a number of factors that are important in assessing a mental health consumer's risk for violence[15].

- Psychosis alone is a statistically significant factor in the likelihood of violence, particularly where there are issues of threat or control.
- The presence of hallucinations alone does not increase the risk unless they evoke negative emotions. Command hallucinations are more likely to be obeyed if they are delusion related, associated with familiar voices or suggest personal superiority, potential benefit or self-worth.
- The more systematised the delusion, the more focussed on the target, the more likely violence will occur.
- Delusions related to threat or control (imagined persecution or manipulation) present a risk and the combination of delusion and fear presents a high risk for violence.
- For schizophrenia, positive symptoms are associated with a greater risk for violence. High negative symptoms, when present on their own, are associated with a reduced risk.
- For mood disorders, psychotic (positive) symptoms increase the risk for violence.
- People experiencing mania tend to be more assaultive when limits are imposed, for example, restricting their movement, but they generally commit less serious acts of violence.

4.3.2 Harmful alcohol or drug use

There is a considerable increase in risk for violence or aggression when there are issues of alcohol or drug use, which can lower impulse control. In addition, the presence of harmful substance use problems can overtake a history of previous violence as the best indicator of future violence.

> 'Consumers suffering major mental illness who abuse alcohol are more likely to commit violence; for substance abuse the likelihood increases significantly.'[16]

When harmful substance use occurs in combination with personality disorder the risk for violence can be elevated. People with borderline personality disorder may demonstrate risky and impulsive behaviour, exhibit self-directed aggression as a strategy to regulate intense negative feelings (e.g. anger, shame or guilt) and display reactive aggression when they feel threatened, provoked or rejected.

Alcohol and many drugs have a disinhibiting effect and increase the probability that the person may act upon violent impulses; stimulants like cocaine or methamphetamine are especially associated with disinhibition, grandiosity and paranoia and contribute towards violent behaviour.

Despite the increasing number of presentations where both mental health and harmful substance use problems are present, often there is a separation between the two regarding treatment planning and delivery.

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[15] Resnik, P (2012). *Assessing risk for violence*. Audio Digest Psychiatry, 41 (23).
[16] Allnutt S H, Ogloff J R P, Adams J, O'Driscoll C, Daffern M, Carroll A, Nanayakkara V and Chaplow D (2013). Managing aggression and violence: The clinician's role in contemporary mental health care. *Australian & New Zealand Journal of Psychiatry*, 47(8): 728–736.

Supervised training should be provided to clinicians about treating consumers with an alcohol or drug use issue (dual diagnosis).

Clinicians will frequently deal with consumers who have dual diagnoses, and they should be competent to provide appropriate care without over-reliance on specialist clinicians within their service.

4.3.3 Childhood experience

Several researchers have reported a strong association between childhood maltreatment and later violence and victimisation in adulthood for those people who display violence or aggression.

- Childhood antecedents of adult violence include parental brutality, and/or having a history of fire-setting or animal cruelty.

> 'It is now well established that people with mental disorders are more likely to have been victims of violence and abuse (and/or to have witnessed it as children) than the general population, and that they continue to be at increased risk of being a victim of violence.'[17]

- The greater the number of different types of early maltreatment the more extensive the violence in adulthood.[18]

4.3.4 Self-harm

Self-harm has been linked to an increased risk for violence. Sahlin et al (2017) conducted a study which demonstrated a link between self-harm and an increased risk for violent offences for both sexes:

> 'DSH [deliberate self-harm] could be viewed as an early behavioural marker of difficulties with emotional and behavioural regulation that, independently of co-occurring psychiatric disorders, may increase the risk of committing violent crimes.'[19]

4.3.5 General

- Threats are more likely to be carried out if they are made to someone who is known to the offender, are made face-to-face or are introduced late in a controversy rather than in the initial heat of a confrontation.
- Either anger or fear often precede violence and may manifest in behavioural and physiological indicators characteristic to the individual:

[17] Khalifeh H, Johnson S, Howard L M, Borschmann R, Osborn D, Dean K, Hart C, Hogg J and Moran P (2015). *British Journal of Psychiatry*, 206 (4): 275-282.
[18] Coid, J W, Ullrich S, Kallis C, Freestone M, Gonzalez R, Bui L, Igoumenou A, Constantinou A, Fenton N, Marsh W, Yang M, DeStavola B, Hu J, Shaw J, Doyle M, Archer-Power L, Davoren M, Osumili B, McCrone P, Barrett K, Hindle D, Bebbington, P (2016). *Improving risk management for violence in mental health services: a multi-methods approach.* Programme Grants for Applied Research, 4(16).
[19] Sahlin H, Kuja-Halkola R, Bjureberg J, Lichtenstein P, Molero Y, Rydell M, Hedamn E, Runeson B Jokinen J, Ljotsson B and Hellner C (2017). Association between deliberate self-harm and violent criminality. *Journal of the American Medical Association*, 74(6): 615-621.

'…the behaviours resulting from more persistent personal traits such as threatening language and increased motor activity are better predictors of assault.'[20]

- The cluster of personality traits associated with violence includes impulsivity, intolerance of frustration or criticism, perpetration of repetitive antisocial acts (e.g. driving recklessly), self-centeredness and projection of blame onto others.

4.3.6 Systemic issues

There may be issues around the care delivery system that contribute to the consumer's frustration and hence the likelihood of aggression or violence. For example, hospital admission and discharge procedures that are not consumer centric or culturally welcoming, long bed waiting times and lack of service provision or capacity all fall into this category.

Regular reviews of service configuration and provision by mental health services is essential to determine if they contribute to the risk of consumers exhibiting violent or aggressive behaviour and, if so, strategies to maximise safety must be developed and monitored.

4.3.7 Aboriginal consumers

When assessing Aboriginal patients, it is beneficial to consider the effects of historical events which have resulted in long term intergenerational trauma, including dispossession through the removal of children, systemic racism and oppression, and discrimination in all aspects of human rights. This can often heighten the Aboriginal consumer's mood level, making the person seem aggressive or abusive upon entry. The clinician's perception and world view or prejudgement can also affect how they view Aboriginal consumers. Aboriginal people have a lack of trust in Western systems due to contributing factors mentioned previously which may cause hypervigilance and poor communication and which often results in what appears to be bad behaviour and possible subsequent forceful removal from premises.

When assessing and treating Aboriginal patients it is important to:

- self-evaluate, ask questions and use a patient-focused approach, avoiding jargon
- be aware of, and avoid, unconscious bias
- address culturally safety needs and instigate cultural supervision that recognises the importance of:
  - the need for health professionals to discuss cultural issues and practices when caring for Aboriginal patients
  - further training and professional development for health professionals about factors that affect assessment and treatment for Aboriginal patients
  - peer support and group supervision
  - healing and debriefing Aboriginal patients
  - addressing vicarious trauma and its impact on Aboriginal people
  - supporting Aboriginal people in high-risk environments
  - traditional practices.

[20] Angland S, Dowling M and Casey D (2014). Nurses' perception of the factors which cause violence and aggression in the emergency department: A qualitative study. International Emergency Nursing, 22: 134-139.

5. Planning care

As part of the care planning process, 3 important questions should be addressed:

- What is it that needs to be known about the person?
- What does the person want to happen?
- To what extent are the person's problems solvable at this time?

Consumers known to exhibit violence or aggression should have a management plan, such as the Consumer Safety Plan, in place identifying triggers that may initiate these behaviours, suitable culturally appropriate prevention and de-escalation strategies and the consumer's responsibilities. The plan should be shared (and updated) in a timely way with other departments or agencies where the consumer is likely to present.

In addition to potential triggers, there may be protective factors that diminish the likelihood of violence and aggression. These should also be considered both in risk assessment and for inclusion in a personal safety plan (see below) to guide the consumer, carers/family and clinician in the future. This plan, focusing on the ability of the individual to positively protect and maintain their own safety, may be a preferred approach to the more traditional care plan, which usually details risk, often with no practical prevention strategies.

Miller (2006) advocates the early exploration of possible protective factors as a non-threatening and engaging approach, which leads to the client opening up and providing more information for a comprehensive assessment than in traditional risk-oriented assessments.[21] Also, from a forensic perspective, Rennie and Dolan (2010) maintain that:

> 'Recognition of protective factors should be an essential part of risk management and interventions to reduce reoffending.'[22]

5.1 Safety planning

In planning to avoid violence or aggression, there should be a focus on positive action to maintain safety. Where comorbidity exists, there should be a comprehensive plan.

Safety plans promote safety and support recovery and must be developed collaboratively between clinicians, the consumer and, where available, their carers/family and personal support person. Initial safety planning must be documented in the action plan section of the mental health Triage document and in the risk management plan section of the RAMP. Where risks are identified, safety plans must be developed for individual consumers. The Consumer Safety Plan can be used for this purpose or Health Service Providers may develop their own service-specific consumer safety plans. The developed safety plan can be incorporated as part of the Treatment, Support and Discharge Plan (TSDP) outlined in the *Mental Health Act 2014.*

The safety plan should be revised and updated at the request of the consumer, carer/family or personal support person and at points of significant transition in care or change/deterioration in clinical state as these represent times of potential increased risk. It should be revisited as part of any post-incident review. The consumer, their carer/family and personal support person should be invited to participate in formal multidisciplinary meetings to develop and review the safety

[21] Miller H A (2006). A dynamic assessment of offender risk, needs, and strengths in a sample of general offenders. *Behavioral Sciences & the Law*, 24: 767–782.
cited in: de Vries Robbé M and Willis G (2017). Assessment of protective factors in clinical practice. *Aggression and Violent Behavior*, 32: 55-63.

[22] Rennie, C. E., and Dolan, M. C. (2010). The significance of protective factors in the assessment of risk. *Criminal Behaviour and Mental Health, 20*(1), 8–22. https://doi.org/10.1002/cbm.750

plan. Opportunities should be provided for them to meet, either separately or together, with key clinicians prior to and after the meetings.

Risk can never be completely eliminated and positive risk management, which recognises that all decisions carry some element of risk, should be integral to the process of safety planning. This approach, which builds on the consumer's strengths and enhances their recovery, is based on a trusting therapeutic relationship and uses the least restrictive practice. It involves:

- working alongside the consumer and their carer/family and personal/cultural support person, weighing up the potential benefits and harms of possible actions
- being willing to make a decision that involves an element of risk where the potential benefits outweigh the risks
- communicating this decision, together with the rationale, to all involved.

While shared responsibility for safety is a principle that underpins the response to people who may be at risk of exhibiting violent or aggressive behaviour, there will be situations where the consumer lacks the decisional capacity to assess the implications of their actions. In these circumstances, a clinician should intervene in the individual's best interests to support their safety and that of others. In these situations, reduced capability for, or outright rejection of, engagement in care should be regarded as a risk factor in its own right, prompting further exploration of strategies to maintain safety. Where the consumer is Aboriginal, an Aboriginal support person must be offered, where practicable and appropriate to do so.

When agreement regarding decisions in the safety plan cannot be reached with consumers, carers/families and personal support people, their views are to be acknowledged, decisions discussed with them, and continued efforts made to assist the individual's responsibility for their own safety and the safety of others. The differing views and reasons for decisions are to be documented in the clinical record.

The content of the safety plan is to be shared with the consumer, their carer/family and their personal support person. If any aspect is not to be communicated, the reason for this decision is to be documented in the clinical record. On discharge, the safety plan, or the contents in the form of a discharge plan, should be available promptly and include currently identified risks with mitigating actions.

6. Delivering care

Much can be done to reduce the likelihood of violent or aggressive events occurring. Suitable assessment, adequate preparation, clinician self-awareness about how they deliver care and how they appear to others and being conscious of the consumer's current situation, their needs and their expectations, can all contribute towards safer care that is more likely to be effective. The practitioner needs to have organisational ability and be capable of developing strategies that work in practice with flexibility to adjust them as circumstances dictate.

Sometimes, the possibility of violent or aggressive incidents occurring can be reduced by the clinician paying attention to how they are perceived by the consumer. The approach taken may not only have an effect in the short term but may also influence whether a person is likely to engage willingly with services in the future. Clinicians should adopt an engaging, non-confrontational approach, with regular contact giving the consumer feedback, keeping them informed and honouring any promises made about future contact. The clinician should avoid giving opinions on issues and grievances beyond their control.

It is important that the clinician is conscious of their own mood, tolerance level and potential behaviour in difficult situations (and considers non-verbal cues they may be conveying, like voice tone and pitch). An aggressive posture and sustained eye contact are to be avoided. If an honest self-appraisal suggests problems, it may sometimes be better to withdraw and hand over to someone else. The clinician should be aware of their own attitude and how engaged they are with the person. They should present as non-judgemental and have considered (and ideally reconciled) any barriers that may impede an open-minded approach. Being constantly alert to both verbal and non-verbal cues from the consumer will help to maintain an appropriate response. There should be a focus on the behaviours, not the personal characteristics of the individual.

Keeping the consumer informed about their current situation and what to expect, for example, the anticipated course of their treatment, ward routines, who each staff member is, waiting times, when they will be seen by a clinician again or how to initiate contact, all make a tremendous difference to how they perceive the care being provided, and often how they are likely to respond to it. As part of involving the consumer in planning their care, reviewing violent or aggressive incidents with them can assist in future prevention.

During interactions with the consumer the clinician should:

- be frank and open and continuously consider the question ‘what do we need to know about this person?’
- consider the consumer’s point of view
- encourage discussion about any issues sooner rather than later
- practise active listening and ask meaningful, relevant and open questions, while encouraging responses and remaining alert to verbal and non-verbal cues
- be aware that revealing some information may indirectly affect carers/family or a personal support person
- be aware of deterioration in the consumer’s mental state and also treat unexpected improvement with caution.

Several papers have identified insufficient communication by mental health staff as a common problem[23] and a study by Ilkiw-Lavalle and Grenyer (2005) revealed disparity in the perceived quality of communication between consumers and staff where significantly fewer staff than consumers thought communication was a problem.[24] Clinicians should ensure that their communications with consumers are clear and that there is a common understanding of what is being said by each party.

The consumer’s perspective should be sought on how they came to be in their present situation and what they hope (or fear) may happen now. Also, the knowledge and experience of carers/family members and the personal support person should be included. The clinician should make a conscious effort to understand the person’s culture, values and any exposure to trauma, including intergenerational trauma and consider how these may affect their behaviour, reaction or response to treatment. While an empathic non-confrontational approach should be used, boundaries should be set where necessary. In a study where forensic inpatients provided their experiences of limit setting:

> ‘An empathic interpersonal style was considered to be important when setting limits; this involves listening and finding out what is happening for the patient and causing them to

[23] Angland S, Dowling M and Casey D (2014). Nurses’ perception of the factors which cause violence and aggression in the emergency department: A qualitative study. *International Emergency Nursing*, 22: 134-139.
[24] Ilkiw-Lavalle and Grenyer B (2005). Differences between patient and staff perceptions of aggression in mental health units. *Psychiatric Services*, 54(3).

be acting in a way that is problematic. An authoritative approach (fair, respectful, consistent, and knowledgeable) was experienced positively by patients and was found to enhance cooperation.'[25]

Clinical and non-clinical administrative staff should also be provided with adequate training, support and periodic debriefing concerning engagement with consumers, which should address topics such as vicarious trauma, showing respect, recognition of warning signs, de-escalation techniques and common countertransference emotions. Poor interactions with administrative staff can have negative consequences for subsequent clinician contact or damage previous work by the clinician to establish a good relationship.

6.1 Recognising the consumer's needs as a person

The clinician should take a person-centred approach based on care, compassion, collaboration and respect to empower the consumer by offering choice wherever possible.

There may also be opportunities to have a positive influence on behaviour where aggression or violence has been a learned and reinforced coping strategy compensating for poor interpersonal skills or social abilities. McGuire (2008) conducted a meta-analytic review of structured programs for adolescents and adults who demonstrated repeated aggression or had been convicted of personal violence:

> 'Emotional self-management, interpersonal skills, social problem solving, and allied training approaches show mainly positive effects with a reasonably high degree of reliability.'[26]

The practitioner should recognise how each consumer's mental health problem might affect their behaviour (for example, their diagnosis, severity of illness, current symptoms and past history of violence or aggression). Clinicians should try to anticipate the impact of the regulatory process on the consumer, for example, being formally detained, having leave declined, having a failed appeal or being in a very restrictive environment and not being allowed to leave the building. Clinicians should also consider any personal factors occurring externally, for example, family disputes or financial difficulties that may affect a consumer's behaviour.

6.2 Carers, family and personal support person

The carer/family or personal support person can be at high risk of suffering from aggression or violence and, in cases of murder, are commonly the victim. Regular communication with the carer/family and personal support person, ensuring they have a copy of the safety plan and seeking their help where necessary sends the message that their involvement is important. If they have been subjected to violence or aggression, this can also provide a level of support and in turn can present unexpected insights or information to inform treatment.

Consumers and their personal support person should always be involved in decisions about care whenever possible. Involving carers/family and the personal support person can also

[25] Maguire T, Daffern M, Martin T. Exploring nurses' and patients' perspectives of limit setting in a forensic mental health setting. Int J Ment Health Nurs. 2014 Apr;23(2):153-60. doi: 10.1111/inm.12034. Epub 2013 Jul 4. PMID: 23822138.

[26] McGuire, J (2008). A review of effective interventions for reducing aggression and violence. *Philosophical Transactions of the Royal Society B*, 363: 2577-2597.

provide historic information, for example, about domestic violence, which may lead to an opportunity to provide education or support.

> 'We do not do enough to educate and prepare families and caretakers on how to manage violence.'[27]

Awareness of how the carer/family or personal support person are faring can assist the clinician in decision-making about respite care (where appropriate) to enable long term on-going care at home to be maintained.

The carer/family and personal support person should be recognised as bringing relevant experience and genuine expertise to the assessment and management of risk. Their input should never be ignored. However, because the experienced clinician will routinely be judging the risk for violence, their professional judgement about safety should not be surrendered purely on the wishes of the family, for example, to allow the person to return home if there are real issues of concern.[28] If the clinician does not agree with the carer/family or support person, they should make extra efforts to view the situation objectively, seeking advice from senior colleagues if necessary and documenting actions taken.

7. Service policies, protocols and culture

Features of the environment or the care delivery system can sometimes contribute to people behaving violently or aggressively. A busy ED, for example, may create difficulties for recognising mental health issues or may mean mental health consumers will not receive appropriate care quickly, which may lead to an escalation in frustration and anger.

Where possible, service settings should avoid excessive stimulation and waiting areas should be comfortable. Consumers' views on this are important to gain an understanding of the environment from their perspective. The process by which consumers are seen should not include any unnecessary delays or repetitive requests for information. They should be kept informed if there is likely to be a significant delay before being seen, in which case they should be offered food and drink. When violent or aggressive situations escalate, and safety permits, consumers should be engaged separately from other service users to minimise any impact.

The importance of good communication cannot be overstated. Services have a responsibility to lay the foundations for effective communication and should:

- create a culture of positive communication
- ensure clinicians are aware of how and when information should be shared
- ensure staff are aware of what is, and is not, appropriate self-disclosure.

The inpatient care setting should accommodate regularly occurring co-morbidity normally encountered in the consumer population, whether this is substance abuse or general physical health issues.

Services should plan for the fact that violent or aggressive incidents will occur and have local policies and practices in place to ensure that staff and the environment have been adequately prepared to minimise their likelihood.

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[27] Freedman R, Randall R, Michels R, Appelbaum P, Siever L, Binder R, Carpenter W, Hatters Friedman S, Resnik P, Rosenbaum J (2007). Psychiatrists, mental illness and violence. *American Journal of Psychiatry*, 164: 9.
[28] Resnik P (2012). *Assessing risk for violence.* Audio Digest Psychiatry, 41(23).
Royal College of Psychiatrists (2008). *Rethinking risk to others in mental health services*. London.

> ‘There is clear international evidence that high-performing health services require clinical and collaborative leadership and a patient safety culture.’[29]

Transfer or transition of care is a crucially important time for effective communication and information sharing. Services should regularly audit the content of discharge letters to ensure details of risk, indicators of relapse and any safety or risk management plans are included.

Communication processes should take account of diverse mental health governance structures (e.g. different policies and standards), which can hinder good communication and hence compromise continuity of care. Services should continually seek to improve information sharing between stakeholders by the use of plans and the communication of alerts and collateral risk information. Memoranda of Understanding between mental health services, other agencies and non-government organisations that promote information sharing, while also highlighting policy and practice differences, can help reduce information siloing and minimise risk.

It is vital that important information is recorded not just in the clinical record, but also in webPSOLIS so that it is available across services (including after hours), to the Mental Health Emergency Response Line, Child and Adolescent Mental Health Service Crisis Connect, RuralLink, mental health staff in EDs, other regions and, through the Co-Response Team, the Police. Safety plans can be effective ways of communicating important information.

8. Education and learning

Adequate professional development for staff requires a culture of learning at all levels of the organisation that encourages and supports continuous improvement, attaches importance to research evidence, nurtures reflective practice and critical thinking, values employee contributions and fosters experimenting with new ideas. This should occur in a framework of team and system based organisational learning[30], strongly supported by senior service management; individual learning alone is not sufficient and is frequently adopted for the wrong reasons, i.e. cost rather than efficacy.

Clinicians and service managers should be aware that certain skills are required to assess why and when behaviour is likely to become aggressive or violent and to be able to avoid or defuse situations. Services should actively support clinicians to develop these skills and not expect that staff will have this awareness intuitively. Employing people with the right attitude and values is of paramount importance and may be supplemented with scenario training to develop clinician capacity to respond appropriately to violent or aggressive incidents.

Mental health services, regardless of setting, should proactively put processes and procedures in place to ensure that all clinicians who are likely to encounter violent or aggressive consumers are competent in assessment and clinical management. This should include cultural awareness training, trauma-informed care training and scenario training.

Training has a role, but only alongside the development of sound clinical skills in daily practice. Clinical supervision is one component of professional development and support for staff engaged in clinical work. All clinical and managerial staff engaged in clinical work require supervision relevant to their experience and expertise.

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[29] New South Wales Health (2017). *The review of seclusion and restraint observation of consumers with a mental illness in NSW health facilities*. New South Wales.

[30] Morgan S (2013). *Risk decision-making: working with risk and implementing positive risk-taking*. Pavilion Publishing and Media, Middlesex, United Kingdom.

> ‘Services should be providing clinical supervision for all clinicians and in different forms and should not be restricted to junior or less experienced clinicians.’[31]

In a stressful situation with consumers, sometimes staff can feel that they have been insulted or their professional judgement has been threatened, and while this may be a normal reflexive reaction, it is essential that it is recognised as such and an effort made to react objectively. This ability may not be gained simply by exposure to a number of violent or aggressive incidents, when the person’s immediate physiological response, or fight-or-flight reaction, may easily mask cognitive resources. Staff should be provided with regular, practical training using typically difficult scenarios where they have an opportunity to experience and analyse their own reactions and countertransference feelings and then adaptively rehearse and develop responses. Recognition and management of these feelings should be delivered as an education subject in its own right, not provided as an adjunct to the physical management of violence and aggression.

Recognising the contribution of differing communication styles, cultural awareness training should be conducted with relevant staff, with particular focus on Aboriginal culture and context. Training and education, including via guidance from Aboriginal peers, may assist clinical staff to recognise and respond appropriately to tension or anxiety in consumers, carers/family and the personal support person.

Trauma-informed care and its significance (based upon the consumer’s previous experience) in comprehending triggers for aggression and violence should be understood by all clinical staff. This will not be achieved by training only; it requires mentorship and regular reinforcement. This is one example of where the knowledge and experience of consumers and their personal support person can make a valuable contribution to training.

Service management should seek out, and give credence to, what clinicians believe will improve their practice and work collaboratively with them and support them to achieve that goal.

While much can be learned from looking back at adverse events, including near misses, much can also be learned from good practice. Mental health services should have processes in place to systematically learn from both adverse events and from situations regarded as exemplars of good care. Processes should be in place to review the appropriateness of the service response and ways in which it could have been improved to identify common factors or patterns that may be amenable to practice and service change. Consideration of cultural appropriateness should also occur, with cultural advisors where available.

The Centre for Mental Health & Safety (2013) developed a framework[32] to review the care of a clinically important sample of patient suicides and homicides where the risk had been rated as low less than seven days before a fatal event. The key findings were:

- It is feasible to develop a framework with which to assess the quality of the risk assessment process.
- In using this framework, the overall quality of risk assessment and management was unsatisfactory in just over one third of the cases reviewed.
- The essence of good risk assessment and management is that they are individual to the patient.

[31] New South Wales Health 2017. *The review of seclusion and restraint observation of consumers with a mental illness in NSW health facilities*. New South Wales.
[32] Centre for Mental Health & Safety (2013). *National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Quality of Risk Assessment Prior to Suicide and Homicide: A pilot study.* United Kingdom.

While this research primarily refers to risk, it also makes recommendations relevant to assessment and management which support the idea that a suitable framework can be effective in guiding best practice and setting practical standards for clinical care in dealing with violence and aggression. Local services should go beyond simple statements about intolerance of violence and aggression and should proactively establish such frameworks to actively guide best practice. In developing such frameworks, perspectives of consumers, carers/family and personal support people should be sought, which may involve follow-up engagement with consumers after de-escalation or recovery.

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